LINCOLN WELLNESS CENTER

Account #____________________________

EVENT BASIC PATIENT INFORMATION

Last Name ______________________________ First Name ____________________ MI ___

Address ____ Apt # __________

City ____ State _____ Zip __________

Primary Phone (   ) __________ Secondary (   ) __________ Work Phone (   ) __________

Date of Birth __________ Sex ( ) M ( ) F Social Security Number ____________________

Student Status ( ) Full-Time ( ) Part-Time ( ) Not a Student

Emergency Contact ____________________________________ Relation __________

Address ____ Phone (   ) __________

City ____ State _______ Zip __________

Patient/Parent's Email Address ____

Race ( ) American Indian or Alaska Native ( ) Asian ( ) Native Hawaiian
( ) Black or African-American ( ) White ( ) Other Race
( ) Other Pacific Islander ( ) Multiple Races

Ethnicity ( ) Hispanic/Latino ( ) Non-Hispanic/Non-Latino

Preferred Language ( ) English ( ) Spanish ( ) Marshallese ( ) Other ____________________
( ) Translator Needed

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT

Patient's Relationship to Guarantor ( ) Self ( ) Child ( ) Spouse ( ) Guardian ( ) Other __________

Guarantor Last Name ______________________ First Name ____________________ MI ___

Primary Phone (   ) __________ Secondary (   ) __________ Work Phone (   ) __________

communityclinic
A HEALTHCARE MINISTRY OF ST. FRANCIS HOUSE NWA

Revised 8/12/2014

LINCOLN WELLNESS CENTER

Account #____________________

Last Name ____________________ First Name ____________________ MI ____

Date of Birth ____________________

SPORTS PHYSICAL EVENT CONSENT FOR TREATMENT AND STATEMENT OF FINANCIAL RESPONSIBILITY

PLEASE READ AND INITIAL EACH STATEMENT BELOW:

________ PERMISSION FOR MEDICAL TREATMENT:
(Initial Here)

- I give permission for the provider and his / her staff to administer needed treatment.
- I understand that no guarantees can be made about treatment results.
- I give permission for supervised students to be present during my visit but I can ask them to leave at any time.
- By signing below I give permission for medical or dental treatment to the person whose name is at the top of this form.

________ PAYMENT RESPONSIBILITY:
(Initial Here)

- I agree to be responsible for the fees and costs involved in the treatment of the above named patient

________ MEDICAL RECORDS DATA ACCESS:
(Initial Here)

- I agree that my protected health information be made available electronically through an electronic health information exchange to other health care providers and health plans that request my information for treatment and payment purposes. I understand that participation in an electronic health information exchange also lets Community Clinic see information about me for treatment and payment purposes. I agree to have my information disclosed to health care payor and the health information exchange.
- I agree to have my medical records used for program evaluation projects and professional research data collection with the understanding that all personal, identifying information will be removed.

________ PRIVACY NOTICE:
(Initial Here)

- I had the opportunity to read and obtain a copy of Community Clinic's Notice of Privacy Practices (HIPAA Form).

THIS FORM MUST BE SIGNED BY THE PATIENT OR THE PATIENT'S PARENT/GUARDIAN BEFORE TREATMENT CAN BE PROVIDED.

I, ______________________________, have read and understand this document.
(Print Name of Patient / Parent / Guardian on the line above)

______________________________ ________________
Patient / Parent / Guardian Signature Date

communityclinic
A HEALTHCARE MINISTRY OF ST. FRANCIS HOUSE NWA

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam ____________________

Name ____________________ Date of birth ____________

Sex ______ Age ________ Grade ________ School ____________ Sport(s) ____________

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: ____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: ____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ____________ Signature of parent/guardian ____________ Date ______

©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

HE0503

LINCOLN WELLNESS CENTER

Account #______________

Patient's Last Name/ Apellido del paciente/ EO AN RI-NAÑINMIJ EO______________________________
Patient's First Name/ Primer nombre/ETAN RI- NAÑINMIJ EO ______________________________
Patient's Mi/2da inicial ______
Patient's Date of Birth/ Fecha de nacimiento/LEN LOTAK EO AN ____________________

PERMISSION TO RELEASE INFORMATION TO SCHOOL

By signing below, I give the Lincoln Wellness Center permission to share with the school that my child is enrolled as a patient at the Wellness Center.

____
Patient / Parent / Guardian Signature

____
Date

____
Print Name Signed Above

PERMISO PARA COMPARTIR INFORMACION CON LA ESCUELA

Al firmar abajo, doy permiso a the Lincoln Wellness Center para compartir con la escuela que mi hijo/a es paciente de The Wellness Center.

____
Firma del paciente / padre / tutor

____
Fecha

____
Nombre en letra molde

MELIM NAN KŌTLAK MELELE NAN JIKUL

ILO AO JAINI ETA, NA IJ KEMELIM LINCOLN WELLNESS CENTER BWE EN KARON JIKUL KO BWE AJIRI E NEJU EJ ENOT JUON RI NANIMEJ ILO WELLNESS CENTER.

____
JAINI ETAM/JINEN AK JEMEN/EO EJ EDDO IN RI NAÑINMIJ EO

____
RAININ

____
DROR ETAM JAINI ITULŌN